



MEMORIAL SLOAN-KETTERING CANCER CENTER
Fourth Year Medical Student Application for Elective Study

To be Completed by Medical Student:

Student's Name: _____

Student's Mailing Address: _____

Student's Telephone Number: _____ Student's E-mail Address: _____

Medical School and Mailing Address: _____

Medical School's Telephone Number: _____

Student's S.S. Number: _____ Student's Birth Date: _____

Elective	Dates		Alternate Elective	Alternate Dates

To be Completed by Dean of Students (or Authorized Official) of Student's School:

The above-named student is in good standing at this institution.

The student is presently in his/her _____ year of a _____ year program, studying for the M.D./D.O. degree. Personal health coverage is/is not in effect while the student is away from school. Malpractice insurance is/is not in effect while the student is away from school. The student is approved to take this elective for credit/not for credit. **(Please include supporting letter of recommendation.)**

Signature: _____

Date: _____

(School Seal)

Name (Print): _____

Title (Print): _____

To be Completed by Graduate Medical Education at Memorial Sloan-Kettering Cancer Center:

Admission of the above-named medical student to the desired clerkship for the period specified is is not approved.

Student should report to: _____

Place: _____ Date: _____ Time: _____

Signature of Elective Sponsor: _____

Return completed application to: Memorial Sloan-Kettering Cancer Center, Graduate Medical Education, Box 187, 1275 York Avenue, New York, New York 10021 (Phone Number: 212-639-6788)